

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3467

CERTIFICATE OF DEATH

03434

Reg. Dist. No. 353

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b Most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home Route #3		d. STREET ADDRESS Route #3	
3. NAME OF DECEASED (Type or print) First Jesse James Middle Briddell Last		4. DATE OF DEATH Month 3 Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1893
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Berlin, Worcester, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Briddell		14. MOTHER'S MAIDEN NAME Ella Pitts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Ella Briddell, Berlin, Maryland		Address Route #3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Hypertensive Cardio-vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 4 hrs 48 hrs 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 Jan , 19 54 , to 3/23 , 19 56 , that I last saw the deceased alive on 3/23 , 19 56 , and that death occurred at 8 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Loory U. Shuler Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) Loory U. Shuler Jr.		DATE SIGNED 3/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-27-56	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		24a. REC'D BY REGISTRAR 4/2/56	24b. REGISTRAR'S SIGNATURE Helen F. Hammond

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. S.

APR 4 1956

RECEIVED

3468 CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Snow Hill</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS LENGTH OF STAY (in this place) <u>2 Weeks</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> STREET ADDRESS (If rural give location) <u>106 Jenkins</u>			
3. NAME OF DECEASED (First) <u>Robert</u> (Middle) <u>Duffy</u> (Last) <u>Duffy</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 10 - 1864</u>	9. AGE last birthday <u>92 1/2</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Small farm</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Sander Duffy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Edell Jones, Snow Hill, md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442 IMMEDIATE CAUSE (A) <u>Uremia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Accident</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardio-vascular Hypertension</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>renal disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days 4 mo</u> <u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/1/56</u> , 19____, to <u>3/15/56</u> , 19____, that I last saw the deceased alive on <u>3/14/56</u> , 19____, and that death occurred at _____ from the causes and on the date stated above. SIGNATURE <u>Paul Grey</u> M.D. ADDRESS (Street, city, town, state) <u>Snow Hill, md</u> DATE SIGNED <u>3/18/56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 18, 56</u>	NAME OF CEMETERY OR CREMATORY <u>Hutts Chapel</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>			
24. REC'D BY REGISTRAR DATE <u>Mar 16, 56</u>	REGISTRAR'S SIGNATURE <u>E. Cooper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Jones, Snow Hill, md</u>				

INSTRUCTIONS
1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
 VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. BIRTH TIME

8. BIRTH WEIGHT

9. BIRTH LENGTH

10. BIRTH HEAD CIRCUMFERENCE

11. BIRTH SKIN COLOR

12. BIRTH HAIR COLOR

13. BIRTH EYE COLOR

14. BIRTH MOUTH COLOR

15. BIRTH NOSE COLOR

16. BIRTH EAR COLOR

17. BIRTH FINGER COLOR

18. BIRTH TOE COLOR

19. BIRTH HEEL COLOR

20. BIRTH PALM COLOR

21. BIRTH SOLE COLOR

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98. BIRTH PALM COLOR

99. BIRTH SOLE COLOR

100. BIRTH HEEL COLOR

BUREAU V. S.

MAR 21 1956

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO THE REQUESTER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THE CERTIFICATE OR FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS. THE REGISTRAR IS NOT TO BE HELD RESPONSIBLE FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS. THE REGISTRAR IS NOT TO BE HELD RESPONSIBLE FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS.

03437

3469

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Quidley</i>		<i>35 yrs</i>		TOWN <i>Quidley</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Clarence A. Hall</i>				<i>March 29 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>male</i>	<i>White</i>	<i>Single</i>	<i>Sept. 27-1884</i>	<i>71</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Merchant</i>				<i>Grain Store</i>		<i>Wango md</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Joseph Hall</i>				<i>Sarah Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or part)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>214-32-6856</i>		<i>Mrs Laverne H. Hall, Newburg md</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<i>Acute Congestive Cardiac Failure</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Atherosclerosis + Coronary Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<i>Arterial Hypertrophy</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>some</i> 19 <i>55</i> to <i>March 29, 1956</i> , that I last saw the deceased alive on <i>Mar. 29</i> , 19 <i>56</i> , and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert L. LaMar</i> M.D.				DATE SIGNED <i>May 30, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>				<i>Shiloh Springs Hill</i>		<i>Quidley md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>April 1, 1956</i>		<i>Elwyn E. Cooper</i>		<i>May 20, 1956</i>		<i>Shiloh Hill, md</i>	

INSTRUCTIONS

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VS A15C 1-55 10M

CERTIFICATE OF DEATH

5223

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF MINISTER OF RELIGION		17. SIGNATURE OF JUDGE		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF CHURCH		21. SIGNATURE OF FUNERAL HOME	
22. SIGNATURE OF BURIAL PLACE		23. SIGNATURE OF CEMETERY		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF CREMATION		26. SIGNATURE OF INCINERATION		27. SIGNATURE OF DISPOSITION	
28. SIGNATURE OF REMAINS		29. SIGNATURE OF IDENTIFICATION		30. SIGNATURE OF RECORDING	
31. SIGNATURE OF INDEXING		32. SIGNATURE OF FILING		33. SIGNATURE OF ARCHIVING	
34. SIGNATURE OF PRESERVATION		35. SIGNATURE OF RESTORATION		36. SIGNATURE OF REPRODUCTION	
37. SIGNATURE OF DISTRIBUTION		38. SIGNATURE OF RELEASE		39. SIGNATURE OF RETURN	
40. SIGNATURE OF RECALL		41. SIGNATURE OF REUSE		42. SIGNATURE OF REPAIR	
43. SIGNATURE OF REPLACEMENT		44. SIGNATURE OF REINFORCEMENT		45. SIGNATURE OF RECONSTRUCTION	
46. SIGNATURE OF REFORMATION		47. SIGNATURE OF REFORMATION		48. SIGNATURE OF REFORMATION	
49. SIGNATURE OF REFORMATION		50. SIGNATURE OF REFORMATION		51. SIGNATURE OF REFORMATION	
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RECEIVED
APR 4 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, any filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3464

CERTIFICATE OF DEATH

03438
Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. LENGTH OF STAY IN 1b 3 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		d. STREET ADDRESS 821 Second St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belden Restorium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle K. Last HENDERSON		4. DATE OF DEATH Month March 31, Day 19 Year 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1871
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George T. Collins		14. MOTHER'S MAIDEN NAME Elizabeth Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fred U. Henderson, Pocomoke, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, right 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis & Arteriosclerosis, severe, gen. Many years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 3, 1948, to March 26, 1956, that I last saw the deceased alive on March 26, 1956, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE N. E. Sartorius, Jr.		ADDRESS (Street, city or town, state) Pocomoke, Md.	
PHYSICIAN'S NAME (Type) N. E. Sartorius, Jr., M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/56	
22c. NAME OF CEMETERY OR CREMATORY Salem Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR APR 5 1956	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Anne White	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED HARRISON		DATE OF DEATH 1956	
AGE 7 months		PLACE OF DEATH HARRISON	
SEX Male		RACE White	
BIRTH DATE 1955		BIRTH PLACE HARRISON	
MARRIAGE None		OCCUPATION None	
EDUCATION None		RELIGION None	
MANNER OF DEATH Natural		CAUSE OF DEATH None	
DISEASE OR INJURY None		TREATMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF JUDGE None		SIGNATURE OF CLERK None	

BUREAU V. S.

APR 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3470

03439

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		Berlin	
TOWN Sinepuxent nr. Berlin				STREET ADDRESS (If rural, give location)		Route # 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highway nr. Berlin							
3. NAME OF DECEASED: (First) Otho		(Middle) Walter		(Last) Henry		4. DATE OF DEATH 3 - 31 - 19 56	
5. SEX: Male	6. COLOR OR RACE: A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 10-16-1916	9. AGE last birthday: 39 yrs.	IF UNDER 1 YEAR: Months 5 Days 25	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Waiter		10b. KIND OF BUSINESS OR INDUSTRY: Night Club		11. BIRTHPLACE (State or foreign country): Berlin, Worcester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Walter Tingle				14. MOTHER'S MAIDEN NAME: Agnes Henry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes <input checked="" type="checkbox"/> (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY No.: 213-12-5601		17. INFORMANT & ADDRESS: Mrs. Edith Henry, Berlin, Md., Route # 3			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Shock and Hemorrhage - accidental DUE TO Compound fracture of skull + lac. Brain Antecedent cause(s) (b) Compression of chest Fract. of multiple ribs DUE TO Fracture of both humeri Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Fracture of neck or femur.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Road - Berlin Rd.)		21c. (City or town) Berlin		(County) Worcester (State) Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Mar 31 56 5:00 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Car Turned over on victim - in rear of car			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Herman A. Ralston</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/31/56 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 4-3-56		NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		LOCATION (City, town, or county) Berlin, Worcester Co., Md. (State)	
DATE REC'D BY LOCAL REG 4/3/56		REGISTRAR'S SIGNATURE <i>Helen F. Hayward</i>		24. FUNERAL DIRECTOR <i>Mary A. Stewart</i> ADDRESS J.F. Stewart Funeral Home, Salisbury, Md.			

BUREAU V. 3

APR 4 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3471

CERTIFICATE OF DEATH

03440

351

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Worcester</i>		STATE <i>MD</i> COUNTY <i>Worcester</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Griddle</i>		TOWN <i>Griddle</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Griddle</i>		LENGTH OF STAY (In this place) <i>69 yrs</i>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) <i>John</i> (Middle) <i>H.</i> (Last) <i>Jackson</i>				4. DATE OF DEATH (Month) <i>March</i> (Day) <i>4</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Sept. 6 - 1886</i>	
9. AGE last birthday <i>69</i>		10. AGE last birthday <i>69</i>		11. AGE last birthday <i>69</i>		12. AGE last birthday <i>69</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saw mill</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saw mill</i>		11. BIRTHPLACE (State or foreign country) <i>Griddle, MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Williams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ind.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT & ADDRESS <i>Mr. Filke Jackson Griddle, MD</i>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>Acute Pulmonary Edema</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension, Cardiac Disease</i>				<i>5 yrs.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Bronchial Asthma & Bronchiectasia</i>				<i>10 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1947</i> , 19....., to <i>March 4</i> , 1956....., that I last saw the deceased alive on <i>March 4</i> , 1956....., and that death occurred at <i>7:30</i> M., from the causes and on the date stated above.							
SIGNATURE <i>John H. LaMar</i> M.D.				DATE SIGNED <i>3-5-56</i>			
23. BURNED, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>March 13, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Boalspring Cemetery</i>		LOCATION (City, town, or county) (State) <i>Griddle, MD</i>	
24. REC'D BY REGISTRAR <i>Mar 6, 56</i>		REGISTRAR'S SIGNATURE <i>E. Cooper</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>May E. Linnis</i>		ADDRESS <i>Griddle, MD</i>	

3211 CERTIFICATE OF DEATH

Back Over 10

1. DECEASED PERSON'S NAME AND ADDRESS

2. PLACE OF DEATH

3. SEX AND AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. EDUCATION

10. RACE

11. RELIGION

12. DATE OF BIRTH

13. PLACE OF DEATH

14. OCCUPATION

15. CAUSE OF DEATH

16. DATE OF DEATH

17. PLACE OF BIRTH

18. MARITAL STATUS

19. EDUCATION

20. RACE

21. RELIGION

22. DATE OF BIRTH

23. PLACE OF DEATH

24. OCCUPATION

25. CAUSE OF DEATH

26. DATE OF DEATH

27. PLACE OF BIRTH

28. MARITAL STATUS

29. EDUCATION

30. RACE

31. RELIGION

32. DATE OF BIRTH

33. PLACE OF DEATH

34. OCCUPATION

35. CAUSE OF DEATH

36. DATE OF DEATH

37. PLACE OF BIRTH

38. MARITAL STATUS

39. EDUCATION

40. RACE

41. RELIGION

42. DATE OF BIRTH

43. PLACE OF DEATH

44. OCCUPATION

45. CAUSE OF DEATH

46. DATE OF DEATH

47. PLACE OF BIRTH

48. MARITAL STATUS

49. EDUCATION

50. RACE

51. RELIGION

52. DATE OF BIRTH

53. PLACE OF DEATH

54. OCCUPATION

55. CAUSE OF DEATH

56. DATE OF DEATH

57. PLACE OF BIRTH

58. MARITAL STATUS

59. EDUCATION

60. RACE

61. RELIGION

62. DATE OF BIRTH

63. PLACE OF DEATH

64. OCCUPATION

65. CAUSE OF DEATH

66. DATE OF DEATH

67. PLACE OF BIRTH

68. MARITAL STATUS

69. EDUCATION

70. RACE

71. RELIGION

72. DATE OF BIRTH

73. PLACE OF DEATH

74. OCCUPATION

75. CAUSE OF DEATH

76. DATE OF DEATH

77. PLACE OF BIRTH

78. MARITAL STATUS

79. EDUCATION

80. RACE

81. RELIGION

82. DATE OF BIRTH

BUREAU V. S.

MAR 21 1956

RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH

3472 CERTIFICATE OF DEATH

Reg. Dist. No. 355

Items 8-9: Film G195 4-18-56 I

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WORCESTER.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS WEST ST.	
3. NAME OF DECEASED (Type or print) First DANIEL Middle KELLEHER Last KELLEHER		4. DATE OF DEATH Month MAR. Day 22 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 01 Days 02 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY P.R.R.	
11. BIRTHPLACE (State or foreign country) COUNTY CORK IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK KELLEHER		14. MOTHER'S MAIDEN NAME MARGARET DENEHOG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 0	
17. INFORMANT MRS. DAN KELLEHER		Address BERLIN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate & Seminal Vesicles 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastases, Cachexia & Anemia DUE TO (c) 3 mo			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 48 , to March 22 , 19 56 , that I last saw the deceased alive on March 22 , 19 56 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hermana Radlins M.D.		ADDRESS (Street, city or town, state) Berlin, Md DATE SIGNED 3/22/56	
PHYSICIAN'S NAME (Type) 0			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 24, 1956	22c. NAME OF CEMETERY OR CREMATORY LONDON PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbay		ADDRESS Berlin Md	24a. REC'D BY REGISTRAR DATE 3-23-56
		24b. REGISTRAR'S SIGNATURE Helen F. Hayward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 27 1956

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03442

3473 CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Worcester</i>		STATE <i>Md</i> COUNTY <i>Worcester</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <i>Stockton</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <i>Stockton</i>	
TOWN <i>Stockton</i>		<i>30 yrs</i>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Yussie W. Manuel</i>				<i>March 6 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>Colored</i>	<i>Widowed</i>	<i>Dec. 22 - 1895</i>	<i>66 1/13 yrs.</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Own home</i>		<i>Greensboro, Va.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Martin Manuel</i>				<i>Sarah Fisher</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>No</i>				<i>none</i>		<i>Miss Pauline Manuel, Stockton</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				<i>Coronary Heart failure</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Arterio-sclerotic hypertension</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<i>Cardio renal disease</i>			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/1/55</i>, 19....., to <i>3/6/56</i>, 19....., that I last saw the deceased alive on <i>3/5/56</i>, 19....., and that death occurred at <i>3:00 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Paul Owen</i>				DATE SIGNED <i>3/7/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<i>Burial</i>				<i>EE Cooper</i>			
DATE THEREOF <i>March 10, 1956</i>				NAME OF CEMETERY OR CREMATORY <i>Methodist</i>			
LOCATION (City, town, or county) <i>Stockton, Md</i>				25. FUNERAL DIRECTOR'S SIGNATURE <i>Clay O. Simmons</i>			
DATE <i>Mar 9, 56</i>				ADDRESS <i>Snow Hill, Md</i>			

CERTIFICATE OF DEATH

Form 10-1-54

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF CONSTABLE

22. SIGNATURE OF ALDERMAN

23. SIGNATURE OF COUNCILMAN

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF TOWNSHIP SHERIFF

26. SIGNATURE OF TOWNSHIP CLERK

27. SIGNATURE OF TOWNSHIP SHERIFF

28. SIGNATURE OF TOWNSHIP CLERK

29. SIGNATURE OF TOWNSHIP SHERIFF

30. SIGNATURE OF TOWNSHIP CLERK

31. SIGNATURE OF TOWNSHIP SHERIFF

32. SIGNATURE OF TOWNSHIP CLERK

33. SIGNATURE OF TOWNSHIP SHERIFF

34. SIGNATURE OF TOWNSHIP CLERK

35. SIGNATURE OF TOWNSHIP SHERIFF

36. SIGNATURE OF TOWNSHIP CLERK

37. SIGNATURE OF TOWNSHIP SHERIFF

38. SIGNATURE OF TOWNSHIP CLERK

39. SIGNATURE OF TOWNSHIP SHERIFF

40. SIGNATURE OF TOWNSHIP CLERK

41. SIGNATURE OF TOWNSHIP SHERIFF

42. SIGNATURE OF TOWNSHIP CLERK

43. SIGNATURE OF TOWNSHIP SHERIFF

BUREAU V. S.

MAR 21 1956

RECEIVED

3474

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>W.</u> Last <u>Mumford</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Mumford</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Henry Mumford</u> Address <u>Bishopville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension + Stroke</u> DUE TO (c) <u>2 yrs ago</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs ago</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 1, 1955</u> , to <u>March 10, 1956</u> , that I last saw the deceased alive on <u>Mar 10, 1956</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D. <u>Berlin Md.</u>				DATE SIGNED <u>3-17-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry G. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>				24a. REC'D BY REGISTRAR <u>3/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Hilda Lynn Berger</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3465

CERTIFICATE OF DEATH

Reg. Dist. No.

03444

350

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Market St.		d. STREET ADDRESS Market St.	
3. NAME OF DECEASED (Type or print) First Middle Last LIBBIE B. PILCHARD		4. DATE OF DEATH Month Year Day 28, 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1885
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira Thomas Pilchard		14. MOTHER'S MAIDEN NAME Elizabeth J. Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Charles W. Pilchard, Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Original attack DUE TO (b) Acute Coronary failure DUE TO (c) Coronary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia - 1st 3 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17, 1956 to March 25, 1956, that I last saw the deceased alive on March 25th, 1956, and that death occurred at 8 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Pocomoke, Maryland	
ACTUAL SIGNATURE N. E. Sartorius M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) N. E. Sartorius, Sr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/56	
22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson		24a. RECEIVED BY REGISTRAR APR 4 1956	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE	

3475

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b Most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Route # 1		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) First Sarah Middle Ellen Last Pitts		4. DATE OF DEATH Month 3 Day 15 Year 56	
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-94
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooking		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Morris		14. MOTHER'S MAIDEN NAME Charlotte Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Myra Purnell, Berlin, Worcester Co. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Diabetes mellitus (c) Myocardial degeneration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		INTERVAL BETWEEN ONSET AND DEATH 1 month Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/15, 1956 , to 3/15, 1956 , that I last saw the deceased alive on 3/15, 1956 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Larry U. Dwyer, Jr.		ADDRESS (Street, city or town, state) Berlin, Md.	
PHYSICIAN'S NAME (Type) Larry U. Dwyer, Jr.		DATE SIGNED 3/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-19-56	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. F. Stewart		24a. REC'D BY REGISTRAR 3-27-56	
24b. REGISTRAR'S SIGNATURE Helen F. Hayward			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete the certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03446

3476

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Stockton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Ward		4. DATE OF DEATH Month March Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1884
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY own	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Ward		14. MOTHER'S MAIDEN NAME Lavina Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Lula M. Ward, Stockton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular renal disease (c) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks unknown 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1955, to March 27, 1956, that I last saw the deceased alive on March 26, 1956, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Cohen		DATE SIGNED M.D. Snow Hill Md.	
PHYSICIAN'S NAME (Type) DR. PAUL COHEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-56	
22c. NAME OF CEMETERY OR CREMATORY Wesley M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Stockton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson		24. REG'D BY REGISTRAR DATE APR 2 1956	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Elwyn Cooper	

CERTIFICATE OF DEATH

3578

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. HARRIS		MALE		45		JAN 15 1911		BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		SIGNS OF LIFE	
1234 E. BALTIMORE ST.		JAN 20 1956		BALTIMORE, MD.		10:00 AM		101.0 F		80		120/80		NONE	
EDUCATION		RELIGION		MARRIAGE		SINGLE		MOTHER'S NAME		FATHER'S NAME		GRANDFATHER'S NAME		GROOMING	
HIGH SCHOOL		METHODIST		MARRIED		NONE		JANE HARRIS		JOHN HARRIS		JOHN HARRIS		CLEAN	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. 1

APR 2 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03447

3477 **CERTIFICATE OF DEATH**

Dr. Grubb

Reg. Dist. No. 351

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Worcester		STATE Maryland		COUNTY Worcester			
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Newark (Ruark)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Newark (Ruark)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 1				STREET ADDRESS (If rural give location) R.D. # 1			
3. NAME OF DECEASED (First) SAMPSON (Middle) MINOS (Last) WEST				4. DATE OF DEATH (Month) March (Day) 26 (Year) 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 24, 1932	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) R.D. Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John E. West				14. MOTHER'S MAIDEN NAME Hettie Ann Kelley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Flora B. West (Wife) R.D. # Newark Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cachexia and malnutrition due to lung abscess and pneumonia						INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) Tuberculosis & cysto degeneration.						6 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cataracts and senile degeneration.						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						5 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 19 53, to March 19 56, that I last saw the deceased alive on March 25, 19 56, and that death occurred at 1:50 A.M. from the causes and on the date stated above.							
SIGNATURE Robert A. Grubb				DATE SIGNED March 24 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Mar. 28, 1956		NAME OF CEMETERY OR CREMATORY Newark Methodist Church Cemetery	
24. REC'D BY REGISTRAR March 28, 1956 Mr. Gurneys				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * SALISBURY MARYLAND	
				LOCATION (City, town, or county) Newark, Maryland		ADDRESS	

3466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Pocomoke City		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 08				d. STREET ADDRESS 803 Second Street			
3. NAME OF DECEASED (Type or print) First Elihu Middle Thomas Last Wilkerson				4. DATE OF DEATH Month March Day 2 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Francis Wilkerson				14. MOTHER'S MAIDEN NAME Charlotte Anne Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-4218		17. INFORMANT Address Mrs Maurice Brimer, Pocomoke, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 322.1 DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius Sr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-2-56	
EXAMINER'S NAME (Type) N. E. Sartorius, Sr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-4-56	22c. NAME OF CEMETERY OR CREMATORY Goodwill Methodist		22d. LOCATION (City, town, or county) (State) RURAL Pocomoke, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Watson				24. REC'D BY REGISTRAR Mar 5 1956			
ADDRESS Pocomoke, Md.				REGISTRAR'S SIGNATURE Dave White			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		EDUCATION		OCCUPATION		MARRIAGE		MILITARY SERVICE		CIVIL SERVICE		OTHER SERVICE		REMARKS	
						</																	